UCSF Benioff Children's Hospital

Neonatal/Pediatric
Referral Transport Checklist

Patient Name_____ Referral Date_____

Referring Hospital_____ Referring Doctor_____

Referral Diagnosis_____

DOB_____ *Birth Time_____ *Birth Weight_____ *GA_____

Present Weight_____ Allergies_____*Apgars_____

Parents Name_____ Parents Phone_____

* = *Neonatal Only*

Essential Information	Yes	No
Copy of patient's chart (including discharge summary/doctors progress notes, 48 hours of nurses notes, recent labs and ABG's, medication record)		
Include 4 copies of face sheet (demographic sheet)		
**Copy of Mother's chart including labs and DR record*		
Copy of X-rays		
**Vit K / Eye Prophylaxis given*		
**Newborn screen done*		
Hx infectious disease exposure		
Immunizations up to date		
Parents available for consent		

Cultures (include date obtained):
Blood_____ Urine_____
CSF_____ ETT_____
Other_____

Laboratory Data (include date & time):
CBC_____
Diff/Plts_____
Electrolytes_____
_____

Oxygenation/Ventilation:_____
FIO2_____ Hood_____ NC_____ LPM____
CPAP_____ FaceMask_____
Mechanical Ventilation_____
Vent Settings_____
ETT Size_____ Lip-Tip_____
X-ray Placement_____
Latest ABG:(date/time)_____

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Present Status:

VS: T_____ HR_____ RR _____ BP _____

Level of Consciousness_____

Glucose_____ HCT_____

Last 12 hrs I & O: In_____ Out_____

Last Void (time) _____ Last Stool (time)_____

Last Fed (time/type/amount)_____

Chest Tubes:

Location: bubbling? Draining?

1. _____

2. _____

Medications

Medication	Dose	Route	Time

Arterial/Venous Access

Type	Site	Solution (+ additives) Running	Rate	X-Ray Position